**Date:** [Date]

**TO:** [Insurance Company Name]
**ATTN:** Prior Authorization Department
**FAX:** [Fax Number]

**RE: Initial Prior Authorization Request for Trigger Point Injections**

**Patient Name:** [Patient Name]
**Date of Birth:** [DOB]
**Member ID:** [Member ID Number]
**Group Number:** [Group Number]

**Provider Name:** [Physician Name]
**NPI Number:** [NPI Number]
**Tax ID:** [Tax ID]
**Phone:** [Phone Number]
**Fax:** [Fax Number]

**Requested Service:** Trigger Point Injection(s)
**CPT Code(s):** [e.g., 20552 or 20553]
**ICD-10 Code(s):** [e.g., M79.1 Myalgia]
**Frequency/Units:** [Number of sessions/muscles requested]

**Clinical Justification:**

The patient has been diagnosed with myofascial pain syndrome characterized by the presence of clinically significant trigger points in the [Insert Muscle Groups, e.g., Trapezius] muscles. The patient has been experiencing chronic pain for [Duration, e.g., 6 months].

**Conservative Treatments Attempted:**

- Physical Therapy: [Dates/Duration] - Result: [Inadequate relief]
- Home Exercise Program: [Duration] - Result: [Inadequate relief]
- Pharmacological Management (NSAIDs, Muscle Relaxants): [Medication names] - Result: [Inadequate relief/side effects]

**Physical Exam Findings:**

Upon examination, the patient exhibits focal tenderness, a palpable taut band, and a local twitch response in the affected muscles. Pain levels are reported as [Pain Scale Score] out of 10, significantly impacting daily activities.

Trigger point injections are medically necessary at this time to reduce pain and improve functional mobility. Documentation including office notes and relevant history is attached for your review.

Sincerely,

[Physician Signature]
[Physician Printed Name]